STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G193	A. BUILDING _____ B. WING _____	C 01/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTVIEW 02	74 "W" ST, NW WASHINGTON, DC 20015

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE
W 000	INITIAL COMMENTS On July 5, 2006, a recertification survey was conducted. It was determined that the facility failed to be in compliance with the Condition of Participation of Client Protections. On August 14, 2006 a follow-up survey was completed and it was determined that the facility was in substantial compliance with the Condition of Participation of Client Protections. A monitoring survey was executed on January 16, 2007. The survey was conducted to verify continued compliance with the Condition of Participation of Client Protections. Six clients (three male and three female) with varying degrees of disability reside in the facility. Three of the six clients were randomly selected for the sample. The findings of the survey were based on interviews and the review of records including incident reports. The results of the survey revealed the facility failed to maintain substantial compliance with the Condition of Participation of Client Protections.	W 000		
W 122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. This CONDITION is not met as evidenced by: Based on interview and record review the facility failed to provide evidence of the prompt notification of parents or guardians of significant incidents (See W148); failed to establish and/or implement policies that ensure clients' health and safety (See W149); failed to ensure that all allegations of abuse were immediately reported to	W 122	W122 See 1374, W148, W149, W153, W154, W155, and W156	02/20/(

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brad R West MD — TITLE: Administrator — (X6) DATE: 2-20-07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 122	Continued From page 1 the administrator or to the Department of Health in accordance with State law, (See W153); failed to thoroughly investigate incidents of abuse (See W154); failed to ensure the prevention of further potential abuse while the investigation was in progress (W155) and failed to report the results of the investigation within five working days (See W156). The effects of these systemic practices results in the failure of the facility to protect its clients and to ensure their general safety and well being.	W 122		
W 148	483.420(c)(6) COMMUNICATION WITH CLIENTS, PARENTS & The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to provide evidence of the prompt notification of parents or guardians of significant incidents, for two of the three clients (Clients #2 and #3) included in the sample. The findings include: 1. (Cross Refer W153) Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's unusual incident reports and corresponding investigative summaries on January 16, 2007 at 11:24 AM revealed the following incidents occurred: a. On September 21, 2006 an incident report	W 148	W148 a. As stated, according to the Incident Report reviewed, persons involved in Consumer #2's care and designated persons of DOH were not notified of the 09/21/06 incident until 10/04/06. The information was faxed to [redacted] on 10/04/06. (See attached fax cover sheet dated 10/04/06) However, the QMRP has notified other parties in writing of the incident (See attached letters) and a copy of the incident report is attached for DOH's review. In the future all parties involved in a consumer's care will receive prompt notification of an incident via telephone by the IMC as soon as ~~sufficient~~ information is gathered. Further details will be provided in writing after medical intervention and further investigation, if warranted, is concluded.	02/

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W 148	Continued From page 2 documented, Client #2 "went into a behavior on the van. She [wanted] to get out the van and I wouldn't let her off. She got mad and hit me in my back. I told don't do that then I [held] her hand down...." Review of the corresponding investigation report (not dated) revealed Client #2 alleged she was " choked" by the staff member on the van. b. An incident dated September 7, 2006 revealed Client #2 was observed in a client's room (at the second provider location) "screaming and hollering" about a staff person "pushing her." The client was then observed to strike a staff person in the chest and then ran into another client's bedroom, "fussing about tearing the house up..." The client was further noted to be cursing. Afterwards, Client #2 was noted to hit the staff person again in the neck and attempted to bite the staff person's hand. The client was then put in a "physical restraint" to "calm her down." Interview with the QMRP on January 16, 2007 at 1:45 PM revealed Client #2 had an aunt that was her legal guardian. At the time of the survey, the facility failed to provide evidence that Client #2's legal guardian had been notified of the aforementioned incident.	W 148	b. According to the Incident Report reviewed, persons involved in Consumer #2's care were notified of the 09/07/06 incident, either the day of or the following day of the incident. (See attached Incident Report dated 09/07/06 and IMC Notification Log) However, according to the Incident Report, designated persons of DOH were not notified of the incident. A copy of the incident report is attached for review by DOH. (See attached Incident Report dated 09/07/06) Please note that Consumer #2 does have an aunt that is involved in her care, however, she is not the legal guardian. Consumer #2's aunt was not notified of the incident at the time, but has since been notified in writing by the QMRP.	02/2
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by:	W 149	According to the Incident Report, her legal guardian, [redacted] was notified of the incident by the IMC on 09/08/07. (See attached IMC Notification Log dated 09/07/06)	

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W 149	Continued From page 3 Based on interview and record review, the facility failed to establish and/or implement policies that ensure the health and safety of one of the three clients (Client #2,) included in the sample. The finding includes: The facility failed to implement their " Incident Management Reporting Protocol" as outlined. (Cross Refer W153) Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's unusual incident reports and corresponding investigative summaries on January 16, 2007 at 11:24 AM revealed the following incidents occurred: a. On September 21, 2006 an incident report documented, Client #2 "went into a behavior on the van. She [wanted] to get out the van and I wouldn't let her off. She got mad and hit me in my back. I told don't do that then I [held] her hand down...." Review of the corresponding investigation report (not dated) revealed Client #2 alleged she was " choked" by the staff member on the van. b. An incident dated September 7, 2006 revealed Client #2 was observed in a client's room (at the second provider location) "screaming and hollering" about a staff person "pushing her." The client was then observed to strike a staff person in the chest and then ran into another client's bedroom, "fussing about tearing the house up..." The client was further noted to be cursing. Afterwards, Client #2 was noted to hit the staff person again in the neck and attempted to bite the staff person's hand. The client was then put	W 149	W149 a. ~~Based on the information given to the IMC at the time of the September 21, 2006 and other circumstances surrounding the incident, clocking the staff person out, who was the Supervisor on duty at that time; was not feasible.~~ It appeared to the IMC that Consumer #2 was the aggressor and the staff member was protecting herself and attempting to follow procedures as outlined in her Behavior Support Plan. However, the two should have been separated in order to give Consumer # 2 an opportunity to calm down. Consumer #2 has a history of striking staff as well as making false allegations that they have harmed her when she becomes upset. During the investigation, she recanted her allegation that the staff member choked her. She also has a history of changing her account of events. However, in the future, to ensure that the consumer is free from harm, the staff person accused by the consumer and/or coworker will be removed from the consumer's care until a thorough investigation is completed despite any previous history of false allegations made by the consumer. The IMC will ~~continue to~~ implement this process along with the Shift Supervisor or Residential Manager if the Supervisor is involved in the incident.	02/20

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W 149	Continued From page 4 in a "physical restraint" to "calm her down." Review of the facility's " Incident Management Reporting Protocol" on January 16, 2007 revealed procedures to be implemented by staff when reporting an incident. According to the policy, the following events should occur: - " If a staff person is directly involved in this incident, i.e. abuse or neglect, [the Incident Management Coordinator] will inform the shift supervisor to clock the involved staff member out until further notice." - "The Incident Management Coordinator will immediately call Answers Please to report the incident. After which she will notify via telephone, not necessarily in this order and depending on the severity of the incident, the QMRP, the Residential Manager, the Administrator, any involved family members, the Case Manager, the attorney, the guardian, and the Department of Health." Documentation of notification should be made on the notification form developed." This will happen as described in Westview Policy VTM 2-21-07 - "If applicable, the written incident report should be forward to the appropriate officials immediately upon its completion or within twenty-four hours after the incident occurred." This will happen as described in Westview Policy VTM 2/21/07 - "Once the investigation report is completed to include findings and recommendations a copy should be forwarded to the Administrator and other appropriate officials within five business days after the incident occurred." This will happen as described in Westview Policy VTM 2/21/07 At the time of the survey, the facility failed to provide evidence that the aforementioned events documented in the " Incident Management	W 149	W149 Continued This practice will be monitored by the Program Director and the Administrator. ~~According to documentation reviewed, all persons involved in Consumer #2's care were notified with the exception of her aunt, [redacted], and a designated person at DOH. (See attached Incident Report and IMC Documentation Log both dated 09/07/06)~~ VTM 2/21/07 b. Based on the information given at the time of the incident ~~it was not warranted that the staff person be sent home because~~ it was observed that Consumer #2 was ~~clearly~~ the aggressor during the incident. As previously noted, Consumer #2 has a history of falsely accusing staff of harming her when she is upset about a separate incident that the staff may not be aware of at the time. However, the accused staff should have been separated from her to allow Consumer # 2 to calm down. In the future, the staff person involved will be removed from the consumer's care until a thorough investigation is completed and a determination is made. An investigation was conducted on September 12, 2006. According to documentation reviewed, it is unclear if a copy was forwarded to the DOH and other appropriate officials. However, a copy was forwarded to the Administrator of Westview, Inc. (See attached Investigation Report dated 09/12/06) (Also see W148, 153, 156)	02/2 VTM 2/21/07

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W 149	Continued From page 5 Reporting Protocol" occurred. (See also W148, W153, W155, and W156)	W 149	W153 a. According to documentation reviewed, the DOH was sent a copy of the Investigation Report via fax on October 4, 2006. The fax was sent by the IMC to the attention of [redacted]. (See attached Fax Cover Sheet dated 10/04/06 and Investigation Report) Documentation does not indicate if the DOH was sent a copy of the Incident Report immediately following the incident. (See attached Incident Report dated 09/21/06) (Also see W149) In the future, all incident reports and investigation reports will be sent to the DOH within the regulated timeframe. This practice will be implemented by the IMC and monitored by the QMRP and Administrator.	02/20
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all allegations of abuse were immediately reported to the administrator or to the Department of Health in accordance with State law, for one of the three clients (Client #2) included in the sample. The findings include: Interview with the Qualified Mental Retardation Professional (QMRP) and review of the facility's unusual incident reports on January 16, 2007 at 11:24 AM revealed the following incidents occurred: a. On September 21, 2006, Client #2 "went into a behavior on the van. She [wanted] to get out the van and I wouldn't let her off. She got mad and hit me in my back. I told don't do that then I [held] her hand down...." Review of the corresponding investigation report (not dated) on January 16, 2007 revealed the following:	W 153	And Administrator VTM 2/2/07 b. ~~According to documentation reviewed, all persons involved in Consumer #2's care were notified with the exception of her aunt, S. Hodges, and a designated person at DOH.~~ [redacted] was notified in writing of the incident and a copy of the incident report is attached for review by DOH. (See attached letter, Incident Report and IMC Documentation Log both dated 09/07/06) The ~~incident~~ report and the investigation report notes that the staff member states that she did not choke Consumer #2 nor did the staff who witnessed the incident observe Consumer #2 being choked by the staff member involved.	

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W 153	Continued From page 6 On September 21, 2006, Client #2 was noted to be on the facility van outside of the provider's second group home. The incident report documented that Client #2 wanted to exit the van to go inside to speak to some of the employees. The report further documented that other clients were boarding the van at the time Client #2 wanted to exit the van. Continued review of the report revealed a staff member informed Client #2 that she could not exit the van. Client #2 was noted to grab the van door handle as the staff member blocked her attempt. The incident report documented that the aforementioned actions occurred repeatedly, at which time Client #2 became agitated. Further review of the investigation revealed the Incident Management Coordinator interviewed Client #2. Review of Client #2's statement revealed Client #2 alleged she was "choked" by the staff member on the van. Additional review of the incident report failed to provide evidence that the Department of Health was notified. Interview with the QMRP on January 16, 2007 revealed that the Department of Health was notified on October 4, 2006. At the time of the survey the facility failed to provide evidence that the Department of Health was immediately notified of the allegation of abuse as required. b. According to an incident report dated September 7, 2006, Client #2 was observed in a client's room (at the second provider location) " screaming and hollering" about a staff person " pushing her." The client was then observed to strike a staff person in the chest and then ran into	W 153	W153 Continued Because Consumer #2 recanted her statement the IMC concluded her investigation and only make mention of the abuse in the investigative report. Also a separate incident report was written and is being submitted to the DOH for review. (See attached Incident Report dated 09/21/07. In the future, all allegations of abuse will be investigated and reported to the proper officials within the regulated timeframe. This practice will be implemented by the IMC and monitored by the QMRP and the Administrator. Please note that because Consumer #2 displayed a noticeable increase in behaviors and aggression she was subsequently admitted to Seaton House at Providence Hospital for Psychiatric Care from 09/08 to 09/13/07. Her medications were changed and at this time aggression and overall behavior status has improved. (See hospital discharge papers dated 09/13/06)	

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W 153	Continued From page 7 another client's bedroom, "fussing about tearing the house up..." The client was further noted to be cursing. Afterwards, Client #2 was noted to hit the staff person again in the neck and attempted to bite the staff person's hand. The client was then put in a "physical restraint" to " calm her down." Review of the corresponding incident investigation dated September 12, 2006 revealed Client #2 "went into a behavior because another consumer, Client #6, took her key chain and would not return it." Review of the summary of statements revealed Client #2 indicated she was upset and tried to "push pass" a staff person. The client further indicated that a staff person " pushed her on the stomach in the struggle." At the time of the survey the facility failed to provide evidence that the Department of Health was immediately notified of the allegation of abuse as required. Note: Additional interview with the QMRP and review of the unusual incident report/investigation revealed the client was hospitalized at a psychiatric facility for four days (September 9, 2006 through September 13, 2006)	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure allegations of abuse were thoroughly investigated, for one of the three clients (Client #2) included in the sample.	W 154		

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W 154	Continued From page 8 The finding includes: 1. (Cross refer W153, a.) Review of unusual incident reports and investigations on January 16, 2007 revealed an incident dated September 21, 2006. According the the investigation report for the aforementioned incident, Client #2 alleged she was choked by a staff member. Continued review of the investigation report revealed an audio recording was conducted of Client #2 at which time she recanted her allegation of being choked. The investigation report failed to document the time and date of the recorded statement. Further review of the investigation report failed to document information regarding when and/or if the facility implemented measures to prevent Client #2 from incurring additional harm. At the time of the survey, the facility failed to provide evidence that the aforementioned incident had been thoroughly investigated. 2. (Cross refer W153, b.) Review of unusual incident reports and investigations on January 16, 2007 revealed an incident dated September 7, 2006. According the the investigation report for the aforementioned incident, Client #2 alleged she was pushed by a staff member. Continued review of the report failed to provide evidence of whether or not the allegation was substantiated. At the time of the survey, the facility failed to provide evidence that the aforementioned incident had been thoroughly investigated.	W 154	W154 1. See W153.a 2. See W153.b In the future all incidents will be throughly investigated by the IMC. All needed information will be included in the investigation report. All evidence or written documentation will be dated, time, & signed. It will be clearly stated in the investigated report if the allegations were substantiated or not. Recommendations will be included in the report. The QRMP will review the investigation report with the IMC upon its completion before forwarding it to the Administrator within 5 days for the final review.	02/20/ 02/20/ 2/21/07
W 155	483.420(d)(3) STAFF TREATMENT OF CLIENTS	W 155		

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W 155	Continued From page 9 The facility must prevent further potential abuse while the investigation is in progress. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to provide evidence that clients were protected from further potential abuse while an allegation of abuse was investigated; for one of the three clients (Client #2) included in the sample. The finding includes: 1. (Cross refer W153, a.) Review of unusual incident reports and investigations on January 16, 2007 revealed an incident dated September 21, 2006. According the the investigation report for the aforementioned incident, Client #2 alleged she was choked by a staff member. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the investigation report (not dated) on January 16, 2007, failed to provide evidence regarding when and/or if the facility implemented measures to prevent Client #2 from incurring additional harm. At the time of the survey, the facility failed to provide evidence that systems were implemented to ensure Client #2 was protected from further alleged abuse. 2. (Cross refer W153, b.) Review of unusual incident reports and investigations on January 16, 2007 revealed an incident dated September 7, 2006. According the the investigation report for the aforementioned incident, Client #2 alleged	W 155	W155 1. See W153.b and W149.a 2. See W153.b and W149.b	02/2 02/2

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W 155	Continued From page 10 she was pushed by a staff member. Continued review of the report failed to provide evidence of whether or not the allegation was substantiated. Interview with the Qualified Mental Retardation Professional (QMRP) and review of the investigation report on January 16, 2007, failed to provide evidence regarding when and/or if the facility implemented measures to prevent Client #2 from incurring additional harm. At the time of the survey, the facility failed to provide evidence that systems were implemented to ensure Client #2 was protected from further alleged abuse.	W 155		
W 156	483.420(d)(4) STAFF TREATMENT OF CLIENTS The results of all investigations must be reported to the administrator or designated representative or to other officials in accordance with State law within five working days of the incident. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure that investigations were reported to the administrator or designated representative with in five working days of the incident, for one of the three clients (Client #2) included in the sample. The finding includes: 1. (Cross refer W153, a.) Review of unusual incident reports and investigations on January 16, 2007 revealed an incident dated September 21, 2006. According the the investigation report for the aforementioned incident, Client #2 alleged she was choked by a staff member. Further	W 156	W156. 1. See W143.a and W148 2. See W153.6 and W148 The ICM will forward a copy of the results of all investigations within 5 working days for final review to the administration and/or designee. VTM 2/21/09	02/20/ 02/20/

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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W 156	Continued From page 11 review of the investigation report revealed it was not dated. At the time of the survey, it could not be determined if the investigation was reported to the administrator within five working days as required. 2. (Cross refer W153, b.) Review of unusual incident reports and investigations on January 16, 2007 revealed an incident dated September 7, 2006. According the the investigation report for the aforementioned incident, Client #2 alleged she was pushed by a staff member. Further review of the investigation report revealed it was signed by the Incident Management Coordinator on September 12, 2006, however, there was no evidence that the results of the investigation was reported to the administrator within five working days as required.	W 156	Please note that a new IMC was put into place on 02/19/07 to aid in ensuring the Incident Management Protocol will be carried out as stated.	02/19/

Health Regulation Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G193	A. BUILDING _____ B. WING _____	C 01/16/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 000	INITIAL COMMENTS A monitoring licensure survey was executed on January 16, 2007. The survey was conducted to verify continued compliance with licensure regulations. Six residents (three male and three female) with varying degrees of disability reside in the facility. Three of the six residents were randomly selected for the sample. The findings of the survey were based on interviews and the review of records including incident reports.	I 000		
I 271	3513.1(b) ADMINISTRATIVE RECORDS Each GHMRP shall maintain for each authorized agency ' s inspection, at any time, the following administrative records: (b) Personnel records for all staff including job descriptions either at the GHMRP or in a central office and made available upon request; This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of all staffs personnel records. The finding includes: Review of the personnel records on January 16, 2007 revealed the GHMRP failed to provide evidence of five staffs personnel records.	I 271	1271 At the time of the survey the personnel folders were available for review by the Department of Health for most of the employees for the facility surveyed. However, the six direct care workers noted in this deficiency report were new employees and their personnel records were not transferred to the facility from the main office at the time of the survey. This was not noted until the survey. The contents of the following employees' record are attached for review: [redacted], [redacted], [redacted], & [redacted]. Please note that [redacted] & [redacted] are no longer employees therefore, their records are not attached. In the future, once the personnel records for new employees are complete a copy of the contents will be sent to the designated facility within five days of being hired. This task will be implemented by the Personnel Manager and followed up on by the Residential Manager of the designated facility.	02/20/0
I 374	3519.5 EMERGENCIES After medical services have been secured, each GHMRP shall promptly notify the resident ' s guardian, his or her next of kin if the resident has no guardian, or the representative of the sponsoring agency of the resident ' s status as soon as possible, followed by written notice and	I 374		

Health Regulation Administration

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Fred R Wurst Jr MD TITLE Administrator (X6) DATE 2/20/07

Health Regulation Administration

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I 374	Continued From page 1 documentation no later than forty-eight (48) hours after the incident. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to provide evidence of the prompt notification to a resident's guardian of the resident's status after receiving medical services, by written notice and documentation no later than forty-eight hours after the incident, for one of the three resident's (Resident #2) included in the sample. The finding includes: (See Federal Deficiency Report - Citation W148 and W153)	I 374	I374 The Incident Management Policy was revised and put into effect on December 6, 2006, after the 09/07/06 and 09/21/06 incident; and after employees were trained on the revisions. The new plan states that the Incident Management Coordinator (IMC) is responsible for notifying all persons involved in the consumer's life. This includes any available family member and/or guardian, case manager, attorney, QMRP, Administrator, and DOH. The IMC should notify each person of initial details of the incident via telephone after he/she is notified. The IMC should then notify ~~each~~ person in writing ~~once more information is obtained and/or final determination of the consumer's status is made by medical personnel~~. This practice is monitored by the Program Director and the Administrator who receives the final report in 5 days. (Also see W148 & W153) DOH within 24 hours VM 2/21/07	02/20/07
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure the Department of Health , Health Facilities Division was notified of unusual incidents that substantially interfered with a resident ' s health, for one of the three residents (Resident #2) included in the sample.	I 379		

Health Regulation Administration

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I 379	Continued From page 2 The finding includes: [See Federal Deficiency Report Citation W153]	I 379	1379 See 1374 and W153	02/20/07

Health Regulation Administration

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R 000	INITIAL COMMENTS A monitoring licensure survey was executed on January 16, 2007. The survey was conducted to verify continued compliance with licensure regulations. Six residents (three male and three female) with varying degrees of disability reside in the facility. Three of the six residents were randomly selected for the sample. The findings of the survey were based on interviews and the review of records including incident reports.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks disclosed the criminal history of any prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. The finding includes: Review of the personnel records on January 16, 2007 revealed that the GHMRP failed to ensure criminal background checks were on file and disclosed a seven year history of all the jurisdictions where the employee resided and worked for six direct care staff.	R 125	R125 At the time of the survey the personnel folders were available for review by the Department of Health for the employees of the facility surveyed. However, the six direct care workers noted in this deficiency report were new employees and their personnel records were not transferred to the facility from the main office at the time of the survey. This was not noted until the survey. The contents, to include criminal background checks or receipts to obtain a final copy, of the following employees' record are attached for review: [redacted], [redacted], [redacted], & [redacted]. Please note that [redacted] & [redacted] are no longer employees therefore, their records are not attached. In the future, once the personnel records for new employees are complete a copy of the contents will be sent to the designated facility within five days of being hired. This task will be implemented by the Personnel Manager and followed up on by the Residential Manager of the designated facility.	02/20/0